Medicare and Home Health Care

This book explains . . .

- The home health benefit and who is eligible.
- What is covered by the Original Medicare Plan.
- How to find a home health agency.
- Where you can get more help.

HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

Table of Contents

What is Home Health Care?

Home Health Care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. This brochure explains Medicare's basic home health benefit and gives you information about where to get more information and help.

Who is Eligible for Home Health Care?

All Medicare beneficiaries can receive home health care benefits. This brochure describes home health care benefits covered by the Original Medicare Plan. If you are in a Medicare managed care plan, see pages 4, 7, 8, and 10.

How Can I Get Care at Home?

To get Medicare home health care:

1. Your doctor must decide that you need medical care in your home, and make a plan for your care at home; and
2. You must need at least one of the following: intermittent (and not full time) skilled nursing care, or physical therapy or speech language pathology services; and
3. You must be homebound. This means that you are normally unable to leave home. Being homebound means that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care; and
4. The home health agency caring for you must be approved by the Medicare program.

The plan of care is described on page 4.

You must meet all four of these conditions for Medicare to cover home health care.

What Does the Original Medicare Plan Cover?

If you meet all four of the above conditions for home health care, Medicare will cover:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Medicare will cover any of these kinds of therapy for as long as you are eligible and your doctor says you need them.

- Home health aide services on a part-time or intermittent basis. A home health aide does not have a nursing license. The aide provides services that support any services that the nurse provides. These services include help with personal care, such as bathing, using the toilet, or dressing. These types of services do not need the skills of a licensed nurse. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your illness or injury.
- Physical therapy, speech language pathology services, and occupational therapy for as long as your doctor says you need it. Medicare covers these types of therapy:

  1) Physical therapy, which includes exercise to regain movement and strength to a body area, and training on how to use special equipment or do daily activities, like how to get in and out of a wheelchair or bathtub.
  2) Speech language pathology services, which includes exercise to regain and strengthen speech skills.
  3) Occupational therapy, which helps you become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. You may continue to receive occupational therapy even if you no longer need other skilled care.
- Medical social services to help you with social and emotional concerns you have related to your illness. This might include counseling or help in finding resources in your community.
- Certain medical supplies, like wound dressings, but not drugs or prescriptions.
- Medical equipment. Medicare usually pays 80 percent of the approved amount for certain pieces of medical equipment, such as a wheelchair or walker.

Medicare and Home Health Care

The Original Medicare Plan covers these home health care services:

Medicare Services	Covered
Part-Time or Intermittent Skilled Nursing Care	x
Part-Time or Intermittent Home Health Aide Services	x
Physical and Occupational Therapy	x
Speech Language Pathology Services	x
Medical Social Services	x
Medical Supplies (not drugs or biologicals)	x
Durable Medical Equipment	x*

*The Original Medicare Plan usually pays 80% of the approved amount for certain pieces of medical equipment. You may have to pay 20% of the approved amount for durable medical equipment. Ask your supplier "Do you accept assignment?" Assignment could save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of "Does your doctor or supplier accept assignment?"

What Doesn't the Original Medicare Plan Cover?

Medicare does not pay for the following:

- 24-hour per day care at home.
- Prescription drugs.
- Meals delivered to your home.
- Homemaker services like shopping, cleaning and laundry.
- Personal care given by home health aides, like bathing, using the toilet, or help in getting dressed when this is the **only** care you need.

What Happens if I Join a Medicare Managed Care Plan?

Medicare managed care plans are health care choices in some areas of the country. In most plans you can only go to doctors, specialists or hospitals on the plan's list. Medicare managed care plans must cover all Medicare Part A and Part B health care, including home health care. Some plans cover extras, like prescription drugs. If you belong to a Medicare managed care plan, you need to call your plan's benefit administrator to see what your plan covers, your appeal rights, and your costs.

What is a Plan of Care?

Your plan of care is written just for you. It describes the care you need, who should give the care, and any special equipment and foods that you might need.

A plan of care describes what kind of services and care you must get for your health problem. Your doctor will work with a home health care nurse to decide:

- what kind of services you need,
- what type of health care professional should give these services, and
- how often you will need the services.

Your plan may also include things like the kind of home medical equipment you need, what kind of special foods you need, and what your doctor expects from your treatment.

Your doctor and home health agency staff review your plan of care as often as necessary, but at least once every 62 days. If your health problems change, your plan of care will be reviewed and may change. Home health agency staff must tell your doctor right away if your health changes. You will continue to receive home health care as long as you are eligible and your doctor says you need it.

How Long Can I Keep Getting Home Health Services?

To start receiving your home health benefit, your doctor must tell Medicare about your plan of care. Medicare pays for your home health services for as long as you are eligible and your doctor says you need these services. However, the skilled nursing care and home health aide services are paid for only on a part time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that you can receive skilled nursing or home health aide services.

Intermittent means you need home health care for a fairly short period of time.

To decide whether or not you are eligible for home health care, Medicare defines "intermittent" as:

- Skilled nursing care or home health aide services that is needed or given on fewer than seven days each week or less than eight hours each day over a period of 21 days (or less).

For example, Jane's doctor says that she needs a nurse to visit her every day for the next 15 days to care for a wound. The total time that the nurse will be at Jane's house will be less than an hour each day, and Jane only needs the nurse to come for fifteen days. Jane's need for home health care meets the Medicare definition of "intermittent."

Your doctor can increase the number of hours per week you receive care.

Hour and day limits can be increased in special cases when the need for more care is limited and able to be planned ahead.

Once you are receiving home health care, Medicare uses the following definition of part-time or intermittent to make decisions about your coverage:

- Skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week.

For example, Fred has been getting home health care for 3 weeks. Fred's condition is improved, but his doctor would like Fred to continue to get home health care. Fred's doctor says that he needs a nurse to come in 3 days a week for two hours each day (a total of 6 hours) and a home health aide to come in 5 days a week for 3 hours each day (a total of 15 hours). This means that Fred is getting a total of 21 hours of home care per week, which meets Medicare's definition of "part-time or intermittent" home health care.

How Can Medicaid Help Low Income Beneficiaries?

Medicaid is a joint Federal and State program that helps with medical costs for some people with low incomes and limited resources.

Medicaid may pay for homemaker, personal care, and other services that are not paid for by Medicare. To qualify for Medicaid, you must have very low income and few savings or other assets. Medicaid has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income. Medicaid coverage differs from state to state. In all states, Medicaid pays for basic home health care and medical equipment.

For more information about what Medicaid covers for home health care in your state, call your State medical assistance office. If you need the telephone number for your State, call 1-800-MEDICARE (1-800-633-4227 TTY: 1-877-486-2048 for speech and hearing impaired).

The home health agency must tell you how much of your bill will be paid by Medicare.

What Can I Be Billed For?

The home health agency sends bills to Medicare. Medicare pays the full approved cost of all covered home health visits. You may be charged for:

- Medical services and supplies that Medicare does not pay for.
- 20 percent coinsurance for Medicare covered medical equipment, such as wheelchairs, walkers and oxygen equipment. If the home health agency doesn't supply medical equipment directly, they will arrange for a home equipment supplier to provide you with the items you need.

If you are in the Original Medicare Plan, ask your supplier "Do you accept assignment?" Assignment could save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of "Does your doctor or supplier accept 'assignment?'"

Before your care begins, the home health agency must tell you how much of your bill Medicare should pay. The agency must also tell you if any items or services they give you are not covered by Medicare, and how much you will have to pay for them. This must be explained both by talking with you and in writing.

You are protected when your home health care ends.

What Do I Do if Medicare Stops Paying for my Home Health Care?

Home health agencies must give you a notice that explains why and when they think Medicare will stop paying for your home health care. If you get this notice and think you still need home health care and that Medicare should keep paying, you can ask Medicare for an official decision.

To get an official decision, you must:

- Keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this.
- Understand you may have to pay the home health agency for these services.
- Ask the home health agency to send your claim to Medicare so that Medicare will decide if it will pay.

If Medicare decides to pay, you will get back all of your payments, except for any coinsurance for durable medical equipment.

What Do I Do if Medicare is Not Paying for an Item or Service that I Feel Should be Paid for?

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

Who Do I Call with Questions?

If you have questions about your Medicare home health care and you are in the Original Medicare Plan, call your Regional Home Health Intermediary (see pages 12 and 13). If you have questions about home health care and you are in a Medicare managed care plan, call your plan. If you are covered by another kind of supplemental insurance plan, call the plan's member services office.

Look for agencies that say they are "Medicare approved."

How Do I Find an Approved Home Health Agency?

If your doctor decides you need home health care, you have the right to choose the home health agency that gives you needed care and services. Your choice should be honored by your doctor, hospital discharge planner or other referring agency.

It is important to remember that Medicare only pays for home health services that are given by a home health agency that meets Medicare's quality standards and is approved by Medicare. Medicare regularly inspects home health agencies to make sure that these standards are met.

You can find a Medicare approved home health agency by:

- asking your doctor or hospital discharge planner
- using a senior community referral service, or other community agencies who help you with your health care
- looking in your telephone directory in the Yellow Pages under "home care" or "home health care." (Look for home health care agencies that say they are Medicare approved.)

When you start getting home care, Medicare approved home health agencies will ask you a set of questions about your health to help them give you proper care. The home health agency is required to keep this information confidential. You may ask to see this information. The home health agency will explain these questions to you, and give you written information about them.

What if I am in a Managed Care Plan?

It is very important to remember: If you belong to a Medicare managed care plan, your choice of home health agencies is limited to agencies that work with the managed care plan. Call your managed care plan if you have questions about the plan's home health care rules. If you get services from a doctor or a home health care agency that doesn't work with the managed care plan, neither the plan nor Medicare will pay the bill. If you are not sure if you are in a Medicare managed care plan, you can call your local Social Security Administration (SSA) office, or call SSA at 1-800-772-1213. If you would like more information about Medicare managed care plans, call 1-800-MEDICARE (1-800-633-4227).

What Questions Do I Ask When I Choose a Home Health Agency?

Before you choose your home health agency, ask these important questions:

- Is the agency Medicare approved?
- How long has the agency been serving the community?
- Does this agency give the services I need?
- How are emergencies handled?
- Is the agency's staff on duty 24 hours a day, seven days a week?
- What will I be charged for services/supplies?
- Will Medicare or Medicaid pay for the items I need?
- How are my rights protected?
- Can my family and I help decide my plan of care?
- Does the agency teach family members about the type of care being given?
- Who makes sure that the home health care plan is being followed? Does the supervisor make regular visits to the home?
- Who can I call if I have questions or complaints?
- What happens if a home health agency staff person does not come when scheduled?
- Will the agency be in regular contact with my doctor?

A counselor in your State's Health Insurance Assistance Program can help answer your questions.

Where Can I Get Help with My Questions?

Every State, territory, plus Puerto Rico, the Virgin Islands, and the District of Columbia, has a State Health Insurance Assistance Program with counselors who will give you free health insurance information and help.

The counselors should be able to answer your questions about home health care and what Medicare, Medicaid and other types of insurance pay for. In addition, these counselors will help you with Medicare payment questions, questions on buying a Medicare Supplemental Insurance or Medigap Policy or long-term care insurance, dealing with payment denials and appeals, Medicare rights and protections, sending complaints about your care or treatment, or help you in choosing a Medicare health plan. You can find the phone number for your State Health Insurance Assistance Program on pages 14-18.

The Regional Home Health Intermediary is also able to help you with questions about the Medicare Home Health Care benefit in the Original Medicare Plan. The Regional Home Health Intermediary covers several states. You can find the phone number on pages 12-13 under Information Assistance. If you are in a Medicare managed care plan, call your plan with questions about the plan rules on home health care.

How Do I Complain About the Quality of My Care?

If you believe that the home health agency is not giving you good quality care, you should call your state home health hotline. Your home health agency should give you this number when you start getting home health services. Or you can call the Peer Review Organization (PRO) in your state to file a complaint (see pages 14-18).

How Do I Find and Report Fraud?

You are important in fighting Medicare fraud.

Most home health agencies are honest, and use correct billing information. Unfortunately, fraud occurs in the home health industry. It wastes Medicare dollars and takes money used to pay claims. You are important in the fight to prevent fraud, waste and abuse in the Medicare program.

To report Medicare fraud, call 1-800-447-TIPS (1-800-447-8477).

The best way to protect your home health benefit is to know what Medicare covers, and to know what your doctor has planned for you. If you do not understand something in your plan of care, ask questions.

You should look for:

- Visits by home health staff that are not needed.
- Bills for services and equipment you never get.
- Faking your signature or your doctor's signature.
- Pressure to accept items and services that you do not need.
- Items listed on your Medicare Summary Notice or Explanation of Medicare Benefits that you do not think you received.

You also should be careful about activities such as:

- Home health services your doctor did not authorize. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure that your doctor was involved in making those changes.
- A home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free, but they need your number for their records.

To report any suspected home health care fraud, call the Regional Home Health Intermediary for your state (see pages 12 and 13), or call 1-800-447-TIPS (1-800-447-8477). Each call is taken seriously.

Important Telephone Numbers

The following pages have telephone numbers that you can use if you need more information.

Learn more about Medicare by calling the national toll-free number, 1-800-MEDICARE (1-800-633-4227). You can also look on the internet at www.medicare.gov to get help with your Medicare questions.

For the most up to date phone numbers, visit the Important Contacts section of this website .

Definition of Important Terms

Approved Amount: The fee Medicare sets as reasonable for a covered medical service. It may be less than the actual amount charged. Approved amount is sometimes called "approved charge."

Durable Medical Equipment: Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Health Care Financing Administration (HCFA): The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Program, and works to make sure that the beneficiaries in these programs have access to high quality health care.

Homebound: Normally unable to leave home. Leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for nonmedical reasons, such as a trip to the barber.

Home Health Agency: An organization that provides home care services, including skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.

Home Health Care: Skilled nursing care and certain other health care that you get in your home for the treatment of an illness or injury.

Medicare: A health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD), (people with permanent kidney failure who need dialysis or a transplant).

Medicaid: A joint Federal and State program that helps with medical costs for some people with low incomes. Programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary: Services or supplies that:

- are proper and needed for the diagnosis, or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Out-of-Pocket Costs: Health care costs that you must pay on your own because they are not covered by Medicare.

Plan Of Care: A plan written by your doctor that describes what kind of services and care you must receive for your health problem.

Provider: A doctor, hospital, health care professional, or health care facility.

Regional Home Health Intermediaries: A private company that contracts with Medicare to process claims and make checks of home health care.

***Skilled Nursing Care:** A level of care that must be given or supervised by licensed nurses and is under the general direction of a doctor. All of your needs are taken care of with this type of service, including giving direct services. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely performed by an average nonmedical person (or one's self) without the direct supervision of a licensed nurse is not covered.

State Health Insurance Assistance Program (SHIP): A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to Medicare beneficiaries.

*This definition, whole or in part, was used with permission from Walter Feldesman, Esq., *Dictionary of Eldercare Terminology*, © 1997.

Index

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